

Preventive and Routine Health Care Services

TRICARE beneficiaries have a variety of preventive and routine services available to keep them healthy and help identify potential problems down the road. It is therefore important to understand the differences between preventive and routine care, and how TRICARE covers each.

Preventive Services

Preventive services are a covered benefit to help beneficiaries stay healthy. Preventive care includes diagnostic procedures, such as cancer and cardiovascular screenings, immunizations, well-child care and infectious disease screenings.

There are limitations on the frequency of preventive care, and coverage varies depending on whether a beneficiary

is using TRICARE Prime, TRICARE Standard or TRICARE Reserve Select.

Preventive services are provided without referrals, with the exception of civilian provider care for active duty service members.

Routine Services

TRICARE defines routine care as any care that is not for an urgent or emergency situation. Routine services may be covered if there is an underlying medical necessity and if the service is covered by TRICARE.

TRICARE-covered routine services include individual provider services (e.g., office visits, diagnosis and treatment by specialists), allergy testing and treatment, osteopathic

manipulation (except chiropractic care) and rehabilitation services.

A referral or authorization may be required for some routine services. Refer to www.triwest.com/provider for referral and authorization requirements.

When billing for these services, remember that TRICARE coverage is based on medical necessity, and diagnoses should reflect that. Be sure to use the correct Current Procedural Terminology (CPT®) and ICD-9 codes when billing, and choose a specific diagnosis.

For more information, refer to the *Medical Coverage* section of your *TRICARE Provider Handbook*. ■

New TRICARE Provider Seminars Available

TriWest Healthcare Alliance Corp. (TriWest) is offering its new series of TRICARE provider educational seminars* throughout the 21-state TRICARE West Region. The seminars, which begin on April 1 and run through mid-June, provide you and your staff with the latest information on TRICARE.

For those who are new to TRICARE, these seminars are a great opportunity to learn about TRICARE programs, policies and procedures. The seminars can also serve as a good update for those who have previously attended a TRICARE seminar. If you have previously attended a seminar and feel comfortable with the TRICARE program, you may want to encourage another team member from your office to attend.

New reference tools will be provided, and the 2008 *TRICARE Provider Handbook* and *Quick Reference Charts*

will be given to each attendee. Seminars are scheduled for both medical/surgical and behavioral health care providers.

By registering online at www.triwest.com/provider, you will receive e-mail confirmation of your registration, reminder e-mail notices prior to the scheduled seminar and eligibility to participate in a drawing for a small prize at the seminar.

Go to www.triwest.com/provider and visit the “Stay Updated” section to find the dates, times and locations of seminars near you. If you need further assistance with registering for a seminar, please e-mail pseminar@triwest.com. ■

* The seminars run approximately 2.5 hours; however, the end time may vary based on level of audience participation.



TRICARE and Other Health Insurance Claims Processing

TRICARE defines other health insurance (OHI) as any non-TRICARE health coverage that is not considered a TRICARE supplement. The following table outlines the order of benefit determination and shows which coverage is primary and which is secondary when a beneficiary has both TRICARE and OHI.

Beneficiary has TRICARE and the Following OHI:	Primary	Secondary
Medicare	Medicare	TRICARE
Medicare Supplement	Medicare Supplement	TRICARE
Commercial Insurance Plan	Commercial Insurance Plan	TRICARE
Medicaid	TRICARE	Medicaid
Indian Health Service	TRICARE	Indian Health Service
TRICARE Supplement	TRICARE	TRICARE Supplement

Remind your beneficiaries that they must follow all rules of the primary insurance (including authorization), otherwise TRICARE will not participate in the claim. **Note:** Active duty service members (ADSMs) are not subject to coordination-of-benefit rules. TRICARE is always the primary payer for ADSMs.

You are encouraged to ask your beneficiaries about OHI so that the correct information is submitted on the claim and proper procedures are followed. Since OHI status can change at any time, it is important to obtain this information on a routine basis.

If a beneficiary's OHI status changes, be sure to update your patient billing system records to avoid delays in claim payments. If a provider indicates that there is no OHI, but the Defense Enrollment Eligibility Reporting System (DEERS) or claims system indicates otherwise, notification from the beneficiary will be required to inactivate the OHI record. The beneficiary should call 1-888-TRIWEST (1-888-874-9378) to update his or her OHI information or complete the *TRICARE Other Health Insurance (OHI) Form*, available at www.triwest.com/provider.

OHI Claim Submissions

When submitting both paper and Electronic Data Interchange OHI claims, you must enter complete

information from the OHI explanation of benefits (EOB) on the claim. Indicate the amount paid by the OHI to include the amount you need to write off according to the OHI's policies.

If submitting a paper claim, you may be asked for a copy of the primary insurer's EOB. For example, if the paper claim indicates the OHI paid \$0, TRICARE needs to know how the OHI processed the claim and would need to refer to the OHI's EOB for this information since there is no way to indicate this on a paper claim. The primary EOB must contain the following information:

- Definition of any "reason codes" used by the primary payer to describe how the claim was processed, when applicable
- Action taken by the primary payer for each specific date of service and charges, when applicable

Claims submitted without this information will be denied.

Note: TriWest Healthcare Alliance Corp. (TriWest) pays claims containing OHI line by line, i.e., if the OHI pays on some lines and not others, TriWest will consider each service on its own merit. The TRICARE EOBs show the beneficiary's responsibility. If the beneficiary's responsibility is "\$0," the beneficiary cannot be billed.

The following table shows an example of a two-line claim with OHI. The beneficiary has no out-of-pocket expenses in this particular instance.

Billed Amount	OHI-Allowable Amount	OHI Paid	OHI Beneficiary Liability	TRICARE-Allowable Amount	TRICARE Paid
Line 1: \$224	\$200	\$176	\$24	\$100	\$24
Line 2: \$130	\$97	\$68	\$29	\$130	\$29
Total: \$354	\$297	\$244	\$53	\$230	\$53

continued on page 3

TRICARE and Other Health Insurance Claims Processing

continued from page 2

Prior Authorization and OHI

In most cases, prior authorization from TRICARE is not required when the beneficiary has OHI that covers the treatment required. Refer to the prior authorization list at www.triwest.com/provider for a list of exceptions.

TRICARE Prime Point of Service Option

Point of service cost-sharing and deductible amounts do not apply if a TRICARE Prime beneficiary has OHI. For details, refer to your *TRICARE Provider Handbook*.

For more details on calculating payments when TRICARE is the secondary payer, visit www.triwest.com/provider. ■

TRICARE OPSS Implementation Update

The TRICARE outpatient prospective payment system (OPPS) is scheduled to be implemented on May 1, 2009. TRICARE will begin using OPPS to pay claims filed for hospital outpatient services. TRICARE OPPS is mandatory for both network and non-network providers.

TRICARE OPPS applies to all hospitals participating in the Medicare program, with some exceptions (e.g., critical access hospitals, cancer hospitals and children's hospitals). TRICARE OPPS also applies to hospital-based partial hospitalization programs (PHPs) subject to TRICARE's prior authorization requirements, and hospitals or distinct parts thereof that are excluded from the inpatient Diagnosis Related Group (DRG) system, to the extent the hospital (or distinct part thereof) furnishes outpatient services.

TRICARE will adopt Medicare's PHP reimbursement methodology for hospital-based PHPs, i.e., two separate Ambulatory Payment Classification (APC) payment rates: one for days with three services (APC 0172) and one for days with four or more services (APC 0173).

TRICARE also will allow physicians, clinical psychologists, clinical nurse specialists, nurse practitioners and physician assistants to bill separately for their professional services delivered in a PHP. The only professional services that will be included in the per diem are those furnished by clinical

social workers, occupational therapists, and alcohol and addiction counselors.

Temporary Transitional Payment Adjustments (TTPAs) will be in place for all hospitals, both network and non-network, in order to buffer the initial decline in payments upon implementation of TRICARE OPPS. For network hospitals, the TTPAs will cover a four-year period. The four-year transition will set higher payment percentages for the 10 APC codes for emergency room (ER) and hospital clinic visits (APC codes 604–609 and 613–616), with reductions in each transition year. For non-network hospitals, the TTPAs will cover a three-year period, with reductions in each transition year. The table shows the TTPA percentages for APC codes 604–609 and 613–616 during the four-year network hospital and three-year non-network hospital transition periods.

OPPS implementation in rural areas for small hospitals with less than 100 beds and sole community hospitals is currently scheduled to be delayed until January 1, 2010, when the Medicare transitional corridor payments for these hospitals expire.

For more information on TRICARE OPPS implementation, refer to Chapter 13 of the *TRICARE Reimbursement Manual*, available at <http://manuals.tricare.osd.mil>, or visit www.tricare.mil/oppss. ■

Transition Period	Network Hospital ¹		Non-network Hospital ²	
	ER	Hospital Clinic	ER	Hospital Clinic
Year 1	200%	175%	140%	140%
Year 2	175%	150%	125%	125%
Year 3	150%	130%	110%	110%
Year 4	130%	115%	100%	100%
Year 5	100%	100%	100%	100%

1. The transition period for network hospitals is four years. In year 5, TRICARE's payment level will be the same as Medicare's (i.e., 100%).

2. The transition period for non-network hospitals is three years. In year 4, TRICARE's payment level will be the same as Medicare's (i.e., 100%).

TriWest Healthcare Alliance Corp.
P.O. Box 42049
Phoenix, AZ 85080

CONTACTS

TriWest Customer Service
1-888-TRIWEST
www.triwest.com

TRICARE Alaska Office
1-907-743-1800

Wisconsin Physicians Service
(Electronic claims set up)
1-800-782-2680
www.wpsic.com

Express Scripts, Inc. (ESI)
(Pharmacy inquiries)
1-866-DoD-TRRX
1-866-DoD-TMOP
www.express-scripts.com/TRICARE



“Evaluation Only” or “Evaluation and Treatment”?

As a primary care manager, have you wondered whether to request an “evaluation only” or an “evaluation and treatment” referral for your TRICARE Prime beneficiaries? If so, here are some guidelines to follow:

- Request an “evaluation only” referral for specialty care to a network provider for evaluation of a medical concern. With these referrals, you intend to continue managing care of the patient’s condition after you receive the servicing specialist’s clinical recommendations.

- Request an “evaluation and treatment” referral for specialty care to a network provider for an episode of care. With these referrals, the servicing provider intends to conduct both the evaluation and treatment of the patient’s condition for which they are being referred.

For more information about referrals, visit www.triwest.com/provider. ■

